California's Health

Vol. 19, No. 7 · Published twice monthly · October 1, 1961

TODAY'S VISITING NURSE ASSOCIATION PROBLEMS*

CYNTHIA A. DAUCH, Ed.D., Executive Director,
Visiting Nurse Association of Los Angeles, Inc.

When I was asked to speak to you on today's VNA problems, I wrote to 19 directors of visiting nurse associations in Southern California asking what they felt to be problems within their agency. I received replies from 10 of them, listing a total of 42 problems. Obviously we cannot discuss all these problems here today, but I shall attempt to cover those which we are all experiencing in one degree or another. Although they are all interrelated, they may for purposes of discussion be grouped under seven major headings.

First is the problem of inadequate income; next seems to be the problem of finding enough time for the work to be done—particularly as this affects the executive director; third is the problem of unmet staffing needs. Beyond this point, it would be difficult to list the problems in order of importance. There was common concern about increased time required for a nursing visit, and, of course, a consequent rise in the cost of a visit; there was concern over lacks in planning for continuity of care for the patient; concern with the need for more adequate publicity for agency services; and concern with problems of board composition and board orientation.

Inadequate Income

The lack of adequate income or support seems to be the overshadowing problem and a factor in several of the other categories of problems. However, we need to guard against falling into the trap of thinking that inadequate income is the cause of all of our ills, or that increased support would be the solution to all of the problems related to the factor of inadequate income.

Adequate financing is, of course, of basic importance in any public health nursing agency. It is a generally accepted principle that top level responsibility for developing all income resources to the maximum rests with the board of directors of a voluntary agency. Too frequently boards have not taken an aggressive role in discharging this responsibility and executive directors have not prodded them into activity in this area or assumed this responsibility themselves. We need to look at our major sources of income and ask if each one has been developed to yield a maximum return.

In most visiting nurse associations the largest single source of income is the Community Chest or United Fund. Two years ago the California State Department of Public Health made a survey of all of the VNAs in the State. Among the findings reported were total income and the amount of income from various major sources for each VNA. An analysis of this report shows that the percent of income received from the Community Chest or United Fund ranged from a little over 7 percent to over 52 percent, with an average for the State of around 36 percent.

There are, of course, many reasons why one agency is able to secure so little from Community Chest while another is able to secure so much. It seems appropriate to ask what these reasons might be. In what way have we failed to tell our story? Why does the support of our service not command a higher priority in the allocation of funds? What methods or techniques have been used by our more successful colleagues to secure more favorable treatment by the Community Chest? There *are* reasons and we should discover them.

The survey reports the same variation in percent of income received from other major sources. Let us take income from patients' fees. In this instance, the range is from over 9 percent to more than 71 percent, with a State average of almost 26 percent.

We know there are *many* reasons for these variations and that, while the lower percentages may not be desirable, some of the higher percentages may possibly represent *very undesirable* situations and practices. However, we may again very appropriately ask if we are securing as much revenue from this source as we should. Is the percent of income derived from this source out of line with that derived from other sources? Are the people receiving service and able to pay, doing so? Are staff members receiving enough guidance in collecting fees? Have we developed guides which will help the staff nurse to judge the family's ability to pay on some basis other than her own subjective judgment?

The California Medical Care Program for public assistance clients has become a major source of income in many of our visiting nurse associations, but have we investigated and developed all possible sources of income? What have we done toward promoting the inclusion of nursing

* Condensed from an address given at the Annual Meeting of the Southern Section of the Council of Visiting Nurse Associations, May 18, 1961, in Pasadena, California.

care in voluntary pre-payment medical care plans? What have we done about paid memberships in the VNA where these are permitted by the Community Chest? With how many groups have we made contractual agreements to provide service? Are there other groups with whom contracts might also be made?

An examination of annual reports from visting nurse associations throughout the entire country shows a great variety of sources of income other than those more commonly regarded as major sources of income. These include local, State, and national voluntary agencies, local service clubs, prepaid medical care plans, and health department contracts.

This problem of support is not limited to VNAs among health and welfare agencies. Recently, in planning the program for a conference for the executive directors of some of the largest agencies in the Welfare Federation of Los Angeles Area, the number one topic proposed for discussion was that of supplemental fund rasing.

In any case, we must not become too discouraged about this matter of support until we have carefully examined our present sources and have asked if we have done everything possible to bring about maximum yields from those sources. We must also be alert to the possibilities of new sources of support and investigate and develop them.

Not Enough Time

Next in importance among our VNA problems was that of enough time for the work to be done. As one director put it—

> *Time* for the executive director to administer the business of the agency, supervise a staff of registered nurses and licensed vocational nurses, a physical therapist and a secretary-bookkeeper.
>
> *Time* to prepare and teach a program of staff education for a staff with no previous experience or preparation in public health nursing.
>
> *Time* to plan and develop a program of physical rehabilitation for the chronically ill.
>
> *Time* to work with the board of directors, to do public relations, to work with community groups and to serve on the many committees she is asked to serve on because of her position in the community.
>
> *Time* to work with three community chests.

I am sure that we could all add to that list. I know from personal experience how utterly and completely frustrating one's job may be when, in spite of one's best efforts, it is humanly impossible to complete the work that needs to be done and that one wants so much to do.

It seems to me that the first thing that is needed is a careful analysis of the work that is being done. If I may be pardoned for citing a personal experience, I did just that in an earlier job situation. Over a considerable period of time I kept a day by day record of my activities—just seven or eight words quickly jotted down on each line to describe a particular activity, whether it was a five or sixty minute activity. It was very easy then as I went back over this record to see how my time was being consumed, to see where it was being inappropriately spent, and to select those activities which could be delegated to others.

I realize that the executive director who is working without an assistant or an education director or even a supervisor may not be able to delegate, except to her secretary-bookkeeper. She may, however, find that there are responsibilities which she is carrying which could and should more properly be carried by the board. She may also find that there are activities which, under the circumstances, might better be eliminated completely. In any case, I firmly believe that keeping a daily record for a time will help one to make an objective analysis of her job, to weed out activities which might more appropriately be carried by someone else and help to make better use of her limited time.

The board also needs to ask if it is making possible the best use of the director's time. Might not her time be spent more profitably—for the agency and for the community—in other ways? Reducing it to a matter of plain dollars and cents, might she not be able to augment agency income if she had more time to devote to public relations and to the development of sources of revenue?

Another question raised was the amount of time to be allowed for educational or office conferences and workshops. If financing of the agency is to be competent as well as adequate we need to know the cost of the various parts of our program. What is the cost of these conferences and workshops? Certainly, a minimum of educational conferences is essential, but beyond this are the benefits worth the cost? Can we afford them or can we afford not to have them? Possibly we cannot afford *not* to have them.

Another question raised was "How can time be scheduled to give in-service education to the VNA with a small staff and a heavy caseload?" Again, can we afford *not* to provide the time for this in-service education and would a maximization of the yield from various sources of income make it possible for us to be more adequately staffed, with a consequent reduction in caseload?

Unmet Staffing Needs

Closely related to the problem of time and of adequate budgeting for the agency is the question raised by one director, "How can income be increased to make it possible to employ a public health nursing supervisor?" We have rather fully developed the topic of increased sources of support and so shall say nothing more on that point. We do wish to say that possibly the best use the agency could make of available funds would be the employment of a supervisor. A commonly accepted standard of supervisor to staff is that of one supervisor to eight to ten staff. Surely one person cannot be expected to carry the many responsibilities of an executive director and provide adequate supervision for a staff of eight registered nurses, one licensed vocational nurse, and one physical therapist.

Another point regarding adequacy of staff was raised by a director who said, "We are not able to afford a physical therapist on the staff and there is no other agency that provides this service. I feel that the service of a physical therapist would be a great help to many of our patients."

I truly believe you might well consider reducing your staff of nurses by one in order to make it possible to pay the salary of a physical therapist. We have seen remarkable things accomplished by physical therapy and by rehabilitation nursing techniques in which our nursing staff have been assisted by our physical therapy staff. I believe the need for nursing care and visits would be sufficiently reduced by the addition of a well-qualified physical therapist to your staff that you could with complete consistency reduce your nursing staff by one.

Longer Nursing Visits Required

As a result of shorter hospital stays and emphasis on patient rehabilitation and self care, we are finding that our visits require a longer period of time. Therefore, fewer visits can be made in one day, with a consequent increase in the cost of a visit.

I am sure that none of us would wish to return to the time when, by doing everything for the patient, we fostered his dependence upon us, prolonged the period during which he was not able to help himself, and in many cases contributed to and aggravated his disability.

Since we do not wish to return to that earlier situation, let us accept the consequences of this new situation with a more positive attitude. The length of the visit *has* been increased, the number of visits made in a day *has* been reduced, and the cost of the visit *has* been increased, but the values to the patient and his family and the community far outweigh these costs. It could probably be shown that our present day practice of time spent in the rehabilitation of the patient actually results in lower cost to the community, although the individual visit costs more. We do know that by the latter practice the number of our visits will be considerably reduced, that years of visiting may be reduced to months, months to weeks and weeks to days. We have a continuing job to do of interpretation of this matter to boards of directors, Community Chest, United Funds, and those agencies with which we enter into contractual agreements.

Lack of Planning for Continuity of Care

Several agency directors expressed concern over lacks in continuity of care of the patient between the hospital and the home and the failure of hospital personnel to provide for this continuity of care. They wished to know what they might do to encourage the referral of patients to the VNA.

This is an old problem and one that has been of concern to VNAs throughout the entire country for many years. Articles on this subject have appeared in the literature—notably those by Ruth M. Farrissey, describing the experience of the Massachusetts General Hospital in making referrals for continuity of care. A study, originated by the National League for Nursing, and conducted under the auspices of the Institute of Research and Service in Nursing Education at Teachers College, Columbia University, has recently been made in Cleveland, Ohio, on the subject of "Factors Influencing Continuity of Nursing Service." We have secured a preliminary report of this study and have been informed that the full report will be ready for distribution in the fall.

Many of you by this time know of the demonstration project to provide continuity of nursing care between hospital and home that is being carried out in Los Angeles County. The Los Angeles County Health Department, at the request of the Los Angeles County Unit of the California League for Nursing, is sponsoring this research project which is being conducted in the Santa Monica Hospital. It is proposed that the project will determine:

The extent to which referral for nursing care in the home is being made in one general private hospital.

If a referral procedure is possible and feasible with private physician patients in a hospital situation.

The kind of patients and illnesses which are most amenable to nursing care in the home.

The methods most effective in implementing referrals for nursing care.

The cost of establishing and maintaining a referral system within the hospital.

If the institution of a referral program within the hospital shortens the length of hospital stay.

When a problem is so large and so complex as to require two or three years for its thorough study, as it did in Cleveland, and as it will in Los Angeles, it would be foolish to attempt to discuss it in this short time. All I can do is refer you to the literature.

Lack of Personnel to Handle Publicity and Public Relations

Another concern of agency directors is with lack of personnel to provide adequate publicity for agency services.

For a discussion of how an agency can organize a sound public relations program, what that program should include, how it can be carried out continuously, how it can make use of suitable publicity media, I would refer you to Wensley's *Building Sound Public Relations.* I would also refer you to the chapter on Public Relations in her *Community and Public Health Nursing* and to Harold Levy's book on public relations. Another aid is available in *Channels,* the bi-weekly publication of the National Publicity Council. *Channels* provides current information about publicity techniques which have proven effective in health and welfare agencies throughout the entire United States. Consultation service on public relations is available from the National Publicity Council for a small additional charge.

I think we would agree that our directors are hard pressed to find the time for their myriad public relations responsibilities. Therefore, we might consider the role of the board in agency public relations.

The board contributes to an agency's public relations:

By seeing that the agency is doing a good job and one that most needs to be done in the community.

By giving public relations a place in the budget.

By organizing a public relations program and by periodically reviewing that program to determine if it might be improved or changed to bring about better results.

By appointing a public relations committee.

STATE DEPARTMENT OF PUBLIC HEALTH
BUREAU OF HEALTH EDUCATION
2151 BERKELEY WAY
BERKELEY 4, CALIFORNIA

Requests for single copies or for placement on the mailing list may be made by writing to the above address.

Entered as second-class matter Jan. 25, 1949, at the Post Office at Berkeley, California, under the Act of Aug. 24, 1912. Acceptance for mailing at the special rate approved for in Section 1103, Act of Oct. 3, 1917.

The public relations committee is one of the most important of all agency committees. This committee might very well include experts in public relations and publicity who may not be members of the board. It should also include staff representation.

I realize, however, that unless this is an unusually active, dedicated and hard working committee with very good leadership, our executive director may still not have the practical assistance that she needs with the preparation of good public relations materials and all of the details that must be carried out in implementing a good public relations program.

Therefore, might we not give consideration to *sharing* the services of a well qualified public relations or publicity technician? Unless there is someone whose specific responsibility it is to handle the technical aspects of the public relations program, these are very likely to be neglected. I am thinking here particularly of the 12 VNAs within the geographic area of Los Angeles County and the benefits that might accrue to all of us by such an arrangement. Much of the material prepared for use in one community could just as appropriately and effectively be used in another, and each of us might have a much stronger public relations program than we have at present.

Can Smallness be a Problem?

This leads into another problem presented by the president of the board of one of our smallest agencies, who wonders if their *smallness* may be the problem too. Here are several problems presented by this board president:

> A caseload which is too large for one nurse but not large enough to justify the employment of another full-time nurse.
>
> The lack of an office secretary.
>
> A telephone answering service which leaves much to be desired.

I hesitate to say this next only because, as director of the largest VNA in the Council, I may represent *bigness*, which is sometimes suspect. However, I truly believe that services would be improved, would be more efficiently and effectively administered, and that individual patients and the community would benefit by a consolidation of some of our smaller VNAs. It might then be possible to have someone to direct in-service or staff education programs, to have more adequate supervision for staff, to have the services of a physical therapist or possibly even of a nutrition consultant, and to upgrade the qualifications of the staff.

Problems Relating to Composition and Orientation of Boards of Directors

Our last problem has to do with board composition and board orientation. One executive director asked that we discuss:

> Methods of motivating board members to learn of the broad trends, objectives and functions within the VNA, this discussion to include the point at which this learning should begin, who can best do the educating, and how.
>
> How to promote changes of board members so that the board represents a cross section of the community, rather than the vested interest of the health group.

A principle which is widely accepted is that the board should be composed of people who parallel the makeup of the community insofar as possible—especially those elements of the community most affected by the agency's program. No public health nursing agency today should be regarded as the private enterprise of any particular section of the community. The base of both the support and the use of public health nursing service is generally community wide. The base of membership on a board should be equally broad. A well rounded board honestly reflects the community for which it acts.

The board of a public health nursing service is intended to be the channel through which the non-nurse, non-medical part of the community expresses its point of view and wishes. If too many people from the health professions are members of the board it ceases to be representative of the community at large.

My own experience tells me that it *is* possible to bring about changes in board membership through an interpretation of these principles, especially to the president.

Once we have a well chosen new member on our board how are we going to orient this member to objectives, functions and trends within the VNA? Where does this learning begin and who can best direct it? This is a *big* topic.

I would again refer to Wensley's *Building Sound Public Relations* in which she includes a section on this very topic. I would also refer you to two *Sample Manuals For VNA Boards and Committees*—those of the Boston and the Brooklyn VNAs—copies of which may be purchased through the National League for Nursing and which are outstanding illustrations of board orientation programs.

I am afraid you will think that I have raised more questions than I have answered. I have approached and undertaken this assignment very earnestly and in all humility—knowing very well that I do not have the answers to the problems that were presented for discussion. All I hoped to do was to raise some questions, to offer a few suggestions, and to ask that we examine together these problems and our attitudes toward them. I hope that together we may find some of the answers, and that we may have a happy experience in working toward the solution of these problems.

MEETINGS SCHEDULED

1961

October 6-7—World Health Conference, Los Angeles

October 25-26—California Conference of Local Health Officers, Semi-Annual Meeting, Yolo County

October 26-28—California Association of Medical Technologists, Annual Meeting, Monterey

October 27—Northern California Public Health Association, Santa Cruz

November 13-17—American Public Health Association, Annual Meeting, Detroit

1962

March 22-24—American Orthopsychiatric Association Meetings, Los Angeles

Municipal Judges to Study Handling of Alcoholic Cases

A section on alcoholism has been created within the framework of the National Association of Municipal Judges; members desiring to affiliate with this section will meet and participate in a special workshop seminar at the association's annual convention in November.

The section on alcoholism is concerned with problems of the court drunk calendar, particularly the processing of the alcoholic defendant. It will study existing court practices and experiments and will make recommendations to municipal courts.

Social Policy in Health Subject of Tahoe Workshop

Social policy in health will be considered at an October 8-11 workshop at the University of California Alumni Center, Lake Tahoe, co-sponsored by the State Department of Public Health and the State Department of Mental Hygiene.

California, in recent years, has shown growing interest in the social forces which influence health. Back of this emerging interest are several factors, including the intensification of health problems which are manifestly socially patterned, such as chronic diseases, mental illness, and alcoholism.

As the close association of the health and social needs of the population have increasingly been recognized, it has become apparent that a social policy for provision of health services has not been defined. Social policy in health means the values, structures, and decisions which determine the course of health programs and their use of resources.

Some 50 persons representing various health and social science professions and with special awareness of the social factors that influence health will attend the workshop, which is financed by the National Institute of Mental Health.

Outstanding social scientists will participate in the program, including Kenneth Boulding, Ph.D., professor of economics, University of Michigan; Miss Elizabeth Rice, associate professor of social work in public health, Harvard University, and John Clauson, Ph.D., director, Institute for Human Development, University of California, Berkeley.

Medical Technologists To Meet

The California Association of Medical Laboratory Technologists will hold its twenty-second annual meeting at Monterey, October 26, 27 and 28 at the Mark Thomas Inn.

The program will include the presentation of a number of scientific papers, among them: "Problems and Pitfalls in the Performance of the L.E. Cell Test" by E. L. Dubois, M.D.; "Plasmacytes and Antibodies in Spleen Tissue Cultures" by C. A. Donz, M.D., "Medico-Legal Aspects of Medical Technology" by Howard Hassard, attorney for the California Medical Association; and "Leukemia and Proliferative Disorders: Recent Developments in Diagnosis" by Jorge Franco, M.D.

A workshop on ultramicro chemical techniques will be held in conjunction with the meeting.

Many recreational activities for participants and their families are being planned. Reservations should be made with Barbara Williams, 15 San Antonio Circle, 6, Salinas, California.

THE ACCIDENT PROBLEM IN CALIFORNIA

This is the second of a series of statistics relating to the accident problem in California. Death statistics are based on data for 1959. Estimates of persons injured and related figures are based on the California Health Survey.

ACCIDENTS AT HOME

Accidents in the home and on home premises cause 33 percent of all accidental deaths in California. There were 1,677 deaths reported as occurring at home in 1959.

Among children under five about 52 percent of all accidental deaths occur at home.

Among persons 65 and over 38 percent of all accidental deaths occur at home.

Accidents in the home are responsible for:

- About 81 percent of all deaths from fire and explosion.
- About 70 percent of all deaths from poisonous gases and vapors.
- About 54 percent of all deaths from falls.
- About 63 percent of all deaths from solid and liquid poisons.
- About 53 percent of all fatal firearms accidents.

Accidents at home injure about 2,051,000 persons each year in California. Each year these accidents injure about 2.8 times as many persons as work accidents and about 3.9 times the number injured in motor vehicle accidents.

Children aged 0-14 show the highest injury rates. Among children, boys have higher rates than girls. The rates for persons over 65 is relatively low. Older women have rates much higher than older men.

Air Pollution Research Meetings Planned for December 1961

The U.S. Public Health Service will join with the California State Department of Public Health December 4 to 7, 1961, in Los Angeles in sponsoring a research conference on motor vehicle emissions and their effects on health. A two and one-half day meeting is planned which will attract scientists from all parts of the United States. Sessions are being planned on the constituents of motor vehicle exhaust, atmospheric reactions, effects of pollutants on visibility and vegetation, effects of pollutants on health, the application of research to control of motor vehicle emissions, and community action for clean air.

In addition to this joint meeting the Department plans to hold a meeting on December 4 with emphasis on two important aspects of medical research: epidemiologic studies of chronic pulmonary diseases with particular emphasis on their relevance to air pollution exposures; and the technical, administrative, and ethical problems of human exposure studies in air pollution.

Californians Appointed to Surgeon General's Committee

Four Californians are members of a special committee appointed by Luther L. Terry, M.D., Surgeon General, to develop long-range objectives for the environmental health programs of the Public Health Service. They are Malcolm H. Merrill, M.D., State Director of Public Health, Leslie A. Chambers, Scientific Director, Allen Hancock Foundation for Scientific Research, University of Southern California at Los Angeles; Seth Gordon, Vice-President, North American Wildlife Foundation, Sacramento; and E. M. Mrak, Ph.D., Chancellor and Professor of Food Technology, University of California at Davis.

The committee is examining both research and operating aspects of the Public Health Service environmental control program which includes surveillance and control of water pollution and water supply, air pollution, radiological health, occupational health, environmental engineering and food protection.

A report of the committee's findings will be prepared around November 1, 1961.

Upswing in Influenza Predicted For Fall and Winter

A recent report from the United States Public Health Service warns that an upswing in the influenza cycle is likely to hit this country during the fall and winter. Asian flu (Type A) outbreaks are predicted since they occur in two to three year cycles and the last outbreak of this type of influenza occurred in March 1960. Type B flu outbreak is overdue for the country since Type B outbreaks generally come in four to six year cycles, and it has been more than six years since there has been much flu of this type in the country. Both types were prevalent in other countries in the 1960-61 influenza season, notably in England where flu was the direct cause of more than 1,000 deaths, and the indirect cause of several more thousands.

The last influenza outbreak in California was a short but severe Type A outbreak during the first three months of 1960.

The lethal impact of an influenza epidemic is reflected not only in the excess mortality due to influenza and pneumonia, but also in an excess of observed deaths due to other conditions as compared to the number of expected deaths for the same period.

During a six-month period in 1957-58 in the United States, almost 60,000 excess deaths were recorded. The 1960 epidemic contributed an excess of 26,000. Of the excess deaths, nearly 85% were attributed to two categories: 33 percent pneumonia-influenza and 51 percent cardiovascular-renal diseases. Among men, the greatest increase in mortality from influenza-pneumonia (50%) was in the age range 55 to 74 years. Among white women the largest relative rise in deaths from pneumonia-influenza was at ages 15-34, the main childbearing period.

Routine annual immunization against influenza is recommended by the Public Health Service and by the California State Department of Public Health for persons over 65, for pregnant women, and for people of all ages who suffer from heart disease, pulmonary disease, diabetes or other chronic debilitating illnesses. Influenza may not be more likely to attack persons in these specified groups than others; the occurrence of influenza in these persons, however, is more likely to be a life-threatening event. Influenza alone places a severe stress on cardiovascular and pulmonary function, and the frequency of bacterial complications is greatly increased in patients with chronic cardiovascular-renal and pulmonary disease.

Studies have demonstrated that influenza vaccine is 60 to 75 percent effective in preventing the disease. Studies also show that morbidity and number of days lost from work were greatly reduced in vaccinated groups.

"Nursing Home Administration" Title of New Publication

"Nursing Home Administration", a guide for training programs, adult education courses, and institutes on the administration and management of nursing homes, boarding homes, and homes for the mentally ill, was released in September upon completion of an extensive nursing home management training project financed by $50,000 from the Public Health Service 1961 General Health Grant. (This project is described in the March 1, 1961, issue of *California's Health*). Authors of the book are John D. Gerletti, Ed.D., C. C. Crawford, Ph.D., both of the University of Southern California; and Donovan J. Perkins, Business Manager of the Attending Staff Association.

Material in the 472-page volume was collected at statewide workshops during which nursing and boarding home administrators stated their problems and proposed areas where help and training were needed. Solutions to problems came from administrators themselves as well as from physicians, nurses and others expert in their respective fields. Included are numerous concrete, practical suggestions for administrators on such subjects as care of patients and guests, working with relatives, public relations, plant housekeeping, records, finances, supplies, meals, personnel, and executive leadership.

The cloth-bound, cleverly illustrated volume may be obtained for $6.50, plus 26 cents sales tax to residents of California from the Attending Staff Association, 7601 East Imperial Highway, Downey, California.

In addition to the book, a 16 page report summarizing the procedure used in the nursing home management training project, as well as project results and recommendations, is available upon request to the Attending Staff Association.

Phenylketonuria Now Eligible for Crippled Children Services

Children with phenylketonuria, a disease which causes mental retardation, have recently become eligible for diagnosis and treatment under the Crippled Children Services program of the California State Department of Public Health. This action implements a new legislative authorization to provide services for children in California with this handicapping condition.

Any child who has a urine test positive for phenylketone bodies, or siblings of a known case of phenylketonuria, are now eligible for diagnosis. Treatment services may be provided when the diagnosis of phenylketonuria has been confirmed at one of the approved medical centers, in accordance with that center's recommendation.

The two centers which are presently approved for treatment of children with this condition are the Neurological Diagnostic Center at the University of California Hospital in San Francisco and the Neurological Diagnostic Center at Children's Hospital in Los Angeles.

Phenylketonuria occurs once in every 20,000 to 40,000 live births and is found in either sex and among all races. While the incidence of this disease is rare, serious mental retardation can result if the condition is not detected early in the life of the child. If it is detected early enough however, it can be controlled by a special diet.

Programs which seek to alter health practices and attitudes constitute efforts to change the local culture; and health innovations are just as subject to selective acceptance and modification as are any other offered or available innovations. Acceptance or modification depends on how the new item or idea is perceived by the recipients, how it accords with their values and assumptions and whether it is consistent with their system of social relationships. It also depends on the social status of the innovator and the implications of that status for the various segments of the community.—M. L. McDonald, *Health Officers News Digest*, Vol. XXVII No. 7-8.

REPORTED CASES OF SELECTED NOTIFIABLE DISEASES CALIFORNIA, MONTH OF AUGUST, 1961

Disease	Cases reported this month			Total cases reported to date		
	1961	1960	1959	1961	1960	1959
Series A: By Place of Report						
Amebiasis	9	88	29	368	323	410
Coccidioidomycosis	14	27	16	110	158	173
Measles	607	554	593	36,916	20,987	38,950
Meningococcal Infections	9	17	7	156	143	146
Mumps	452	998	420	19,584	18,631	9,409
Pertussis	256	292	214	1,382	1,258	1,700
Rheumatic Fever	4	6	6	78	109	100
Salmonellosis	193	155	109	946	846	762
Shigellosis	293	297	212	1,400	1,357	1,147
Streptococcal Infections, Respiratory	669	1,553	1,143	11,337	21,869	15,214
Trachoma	7	4	--	11	88	21
Series B: By Place of Residence						
Chancroid	7	11	5	75	83	47
Conjunctivitis, Acute Newborn	3	--	1	9	12	4
Gonococcal Infections	2,308	1,902	1,371	15,216	12,535	11,058
Granuloma Inguinale	--	--	1	3	10	1
Lymphogranuloma Venereum	--	3	--	4	24	15
Syphilis, Total	773	792	538	5,045	5,366	4,608
Primary and Secondary	148	188	77	1,007	1,056	703
Series C: By Place of Contraction						
Botulism	--	--	--	--	--	2
Brucellosis	--	--	2	15	13	9
Diarrhea of the Newborn	6	--	24	31	6	40
Diphtheria	1	--	--	2	--	4
Encephalitis	32	48	33	312	387	267
Food Poisoning (exclude botulism)	142	32	28	1,513	1,093	1,000
Hepatitis, Infectious	776	619	201	4,377	2,990	1,690
Hepatitis, Serum	26	13	3	151	81	61
Leprosy	--	3	1	8	7	11
Leptospirosis	--	1	--	4	1	2
Malaria	--	8	3	7	8	20
Meningitis, Viral or Aseptic	147	134	151	456	436	472
Plague	--	--	--	--	--	2
Poliomyelitis, Total	12	111	83	61	282	226
Paralytic	10	95	68	50	247	188
Nonparalytic	2	16	15	11	35	38
Psittacosis	--	1	2	8	11	13
Q Fever	1	1	13	26	29	47
Rabies, Animal	17	12	27	155	87	88
Rabies, Human	--	--	--	1	--	1
Relapsing Fever (tick borne)	--	5	--	--	5	--
Rocky Mountain Spotted Fever	--	1	--	--	2	2
Tetanus	2	6	5	18	23	30
Trichinosis	1	1	--	10	2	4
Tularemia	--	--	3	4	2	4
Typhoid Fever	9	7	6	40	32	51
Typhus Fever (endemic)	--	--	2	3	--	3
Other *						
Tuberculosis [1]	--	--	--	3,190	3,606	3,628

* This space will be used for any of the following rare diseases if reported: Anthrax, Cholera, Dengue, Relapsing Fever (louse borne), Smallpox, Typhus Fever (epidemic), Yellow Fever.

[1] Tuberculosis cases are corrected to exclude out of State residents and changes in diagnosis; monthly figures are not published.

Public Health Positions

San Diego County

Supervising Physical Therapist: Salary range, $559 to $616. Duties include planning, organizing, assigning and coordinating the work of physical therapists in the crippled children's program in four elementary schools. California registration required; at least two years of experience within the last five years, including experience with cerebral palsy cases, is required. Write to Department of Civil Service and Personnel, Civic Center, San Diego, California.

Santa Clara County

Public Heath Physician: Salary range, $859-$1044. Must be licensed to practice medicine in California. Pediatric experience desired. Write W. Elwyn Turner, M.D., Director of Public Health, Santa Clara County Health Department, San Jose 28, California.

Tahoe Meeting Considers Long Range Water Policy

A long range policy for water supply and sewage disposal in the entire Tahoe Basin was considered at a meeting in Tahoe City of representatives from the State Departments of Health and Water Resources, Water Pollution Boards, the Interstate Compact Commission, El Dorado and Placer County Health Departments, and Nevada State and local health departments.

The meeting was called by the Lake Tahoe Area Council to brief its recently retained board of consulting sanitary engineers concerning existing State policies and the views of official departments regarding water and sewage problems in the basin.

Frank Stead, Chief, Division of Environmental Sanitation, California State Department of Public Health, stressed the importance of protecting the surface waters of the basin from the damaging impact of sewage, or sewage effluent. Consideration was not only given to the public health implications of such discharge, but to the total spectrum of adverse effects on the quality of water in Lake Tahoe and the surface streams that would result from the discharge of wastes containing a high concentration of plant nutrients and other dissolved or suspended organic materials.

The State Health Department recommended that in addition to the two alternatives under study by the consulting board, that of land disposal and pumping of effluent from the basin, consideration be given to complete reclamation of water from sewage by storage of treated sewage for periods of approximately one year in a system of man-made impoundments.

The final policy decision reached for the Tahoe Basin will have a strategic effect on the policies to be followed in other recreational areas throughout California.

Sixty-five out of every 100 school-age children need dental care now. It is estimated that at least 60 percent of the adult population has not obtained necessary dental care, yet by conservative estimate, the people of California spend over $248,000,000 annually for dental treatment.

Department Radiological Safety Committee Appointed

In order to prepare for increased use of radiation within the California State Department of Public Health, the Department's radiological safety program has been strengthened by the appointment of a department radiological safety committee; by the reappointment of a departmental radiological safety officer; and by the naming of a Department physician who will evaluate employee health and safety in regard to radiation.

The committee, consisting of representatives from the Bureau of Radiological Health, the Bureau of Occupational Health, and the Division of Laboratories, is responsible for giving technical assistance and advice on the use of ionizing radiation; approving applications for radiation uses; preparing a Department safety manual; and advising on Department policy with regard to use of radiation.

The radiological safety officer is responsible for maintaining surveillance over radiation use in the Department and conducting the necessary monitoring. The physician is responsible for evaluation of employee health and safety in regard to radiation.

A physical examination by a specialist must be undergone by everyone who is to work with radioactive materials. Arrangements are made for an annual physical examination of employees who are exposed beyond a specified amount. The amount of exposure is checked by a monitoring system using film badges. Chest badges are used by those generally exposed, while those who handle radioactive sources wear badges on their fingers.

Five laboratories or bureaus within the Department hold licenses permitting possession of radioactive materials.

Radioactive isotopes are used in the Department in a variety of ways: in calibration of equipment used to count radioactivity in environmental samples, in measuring low concentrations of oxidants in air, in determination of the adequacy of lead shielding in barriers around X-ray installations, in viral studies, and in studies of the development of insecticide-resistance in mosquitoes.

A number of X-ray diffraction machines are also in use in the Department.

In addition to controlling potential radiation hazards within the Department, the committee is concerned with controlling the exposure of staff who make inspections and surveys of ionizing radiation equipment outside the Department.

John Knutson, D.D.S., Joins UCLA Staff

John Knutson, D.D.S., Ph.D., Chief Dental Officer, U.S. Public Health Service, has been appointed to the faculty of the new dental school at the University of California at Los Angeles. He will hold the position of Professor of Preventive Dentistry and will also have a joint appointment as Professor of Public Health in Dentistry in the UCLA School of Public Health. He will assume his new position October 1, 1961.

Dr. Knutson has served as Assistant Surgeon General and Chief Dental Officer of U.S. Public Health Services since 1952. Prior to that he was Chief of the Division of Dental Public Health of the Public Health Service. Dr. Knutson received his dental degree from the University of Minnesota and a Ph.D. in Public Health from Johns Hopkins University, Baltimore. He is a past president of the American Public Health Association.

The ratio of physicians to population has remained at about the same level since 1940, although it is lower today than it was in 1900. However, the number of paramedical personnel has risen substantially, and it is generally believed that the productivity of physicians has also increased.—*Progress in Health Services*, Health Information Foundation, Vol. X No. 5.

printed in CALIFORNIA STATE PRINTING OFFICE

49149 9-61 10,500